



## **Texas Department of Insurance**

### **Division of Workers' Compensation**

Medical Fee Dispute Resolution, MS-48

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## **MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION**

### **GENERAL INFORMATION**

#### **Requestor Name and Address**

VISTA HOSPITAL OF DALLAS  
4301 VISTA ROAD  
PASADENA, TX 77504

**DWC Claim #:**

**Injured Employee:**

**Date of Injury:**

**Employer Name:**

**Insurance Carrier #:**

#### **Respondent Name**

TEXAS MUTUAL INSURANCE CO

**Carrier's Austin Representative Box**

# 54

#### **MFDR Tracking Number**

M4-07-3532-02

**MFDR Date Received**

FEBRUARY 6, 2007

### **REQUESTOR'S POSITION SUMMARY**

**Requestor's Position Summary Dated February 16, 2007:** "Carrier may reimburse at a "per diem" rate for the hospital services if the total audited charges for the entire admission are below \$40,000, after the Carrier audits the bill pursuant to the applicable rules. However, if the total audited charges for the entire admission are above \$40,000, the Carrier shall reimburse using the Stop-Loss Methodology in accordance with the plain language of the rule contained in § 134.401(c)(6)(A)(iii). This rule does not require a hospital to prove that services provided during the admission were unusually extensive or unusually costly to trigger the application of the Stop Loss Methodology. It is presumed that the services provided were unusually extensive or unusually costly when the \$40,000 stop-loss threshold is reached."

**Amount in Dispute:** \$37,152.52

### **RESPONDENT'S POSITION SUMMARY**

**Respondent's Position Summary Dated February 22, 2007:** "The admission did not have services that were unusually extensive or unusually costly and total audited charges do not exceed the minimum threshold of \$40,000. Payment under the stop-loss exception has not been justified by the hospital in this case, and Texas Mutual's payment under the per diem plus carve-outs method is appropriate."

**Response Submitted by:** Texas Mutual Insurance Company

### **SUMMARY OF FINDINGS**

Disputed Dates	Disputed Services	Amount In Dispute	Amount Due
September 22 to 24, 2006	Inpatient Hospital Services	\$37,152.52	\$0.00

## ***FINDINGS AND DECISION***

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

### **Background**

1. 28 Texas Administrative Code §133.240, 31 *Texas Register* 3544, effective May 2, 2006, sets out the procedures for medical payments and denials.
2. 28 Texas Administrative Code §133.2, 31 *Texas Register* 3544, effective May 2, 2006, sets out the definition of final action.
3. 28 Texas Administrative Code §133.305 and §133.307, 31 *Texas Register* 10314, applicable to requests filed on or after January 15, 2007, sets out the procedures for resolving medical fee disputes.
4. 28 Texas Administrative Code §134.401, 22 *Texas Register* 6264, effective August 1, 1997, sets out the fee guidelines for inpatient services rendered in an acute care hospital.
5. 28 Texas Administrative Code §134.1, 31 *Texas Register* 3561, effective May 2, 2006, sets out the guidelines for a fair and reasonable amount of reimbursement in the absence of a contract or an applicable division fee guideline.

The services in dispute were reduced/denied by the respondent with the following reason codes:

#### **Explanation of Benefits**

- CAC-W1 – Workers compensation state fee schedule adjustment.
- 480 – Reimbursement based on the acute care inpatient hospital fee guideline per diem rate
- CAC-97 – Payment is included in the allowance for another service/procedure.
- 730 – Denied as included in per diem rate.
- W10 – No maximum allowable defined by fee guideline. Reimbursement made based on insurance carrier fair and reasonable reimbursement methodology.
- CAC-143 Portion of payment deferred.
- 420 – Supplemental payment.
- 426 – Reimbursed to fair and reasonable
- CAC-W4 – No additional reimbursement allowed after review/appeal.
- 891 – The insurance company is reducing or denying payment after reconsideration

Dispute M4-07-3532 was originally decided on October 16, 2008 and subsequently appealed to a contested case hearing at the State Office of Administrative Hearings (SOAH) under case number 454-09-1674.M4. This dispute was then remanded to the Texas Department of Insurance, Division of Workers' Compensation (TDI-DWC) pursuant to a February 16, 2009 SOAH order of remand. As a result of the remand order, the dispute was re-docketed at medical fee dispute resolution and is hereby reviewed.

### **Issues**

1. Did the respondent provide sufficient explanation for denial of the disputed services?
2. Did the audited charges exceed \$40,000.00?
3. Did the admission in dispute involve unusually extensive services?
4. Did the admission in dispute involve unusually costly services?
5. Is the requestor entitled to additional reimbursement?

### **Findings**

This dispute relates to inpatient surgical services provided in a hospital setting with reimbursement subject to the provisions of division rule at 28 Texas Administrative Code §134.401, titled *Acute Care Inpatient Hospital Fee Guideline*, effective August 1, 1997, 22 *Texas Register* 6264. The Third Court of Appeals' November 13, 2008 opinion in *Texas Mutual Insurance Company v. Vista Community Medical Center, LLP*, 275 *South Western Reporter Third* 538, 550 (Texas Appeals – Austin 2008, petition denied) addressed a challenge to the interpretation of 28 Texas Administrative Code §134.401. The Court concluded that "to be eligible for reimbursement under the Stop-Loss Exception, a hospital must demonstrate that the total audited charges exceed \$40,000 and that an admission involved unusually costly and unusually extensive services." Both the requestor and respondent in this case were notified via form letter that the mandate for the decision cited above was issued on January 19, 2011. Each party was given the opportunity to supplement their original MDR submission, position or response as applicable. Neither party responded. The documentation filed to the division

by the requestor and respondent to date is considered. Consistent with the Third Court of Appeals' November 13, 2008 opinion, and 28 Texas Administrative Code §134.401(c)(6), the division will address whether the requestor demonstrated that: audited charges **in this case** exceed \$40,000; the admission and disputed services **in this case** are unusually extensive; and that the admission and disputed services **in this case** are unusually costly.

1. 28 Texas Administrative Code §133.240(a) and (e), 31 Texas Register 3544, effective May 2, 2006 and applicable to the dates of service, state, in pertinent part, that " (a) An insurance carrier shall take final action after conducting bill review on a complete medical bill..." and "(e) The insurance carrier shall send the explanation of benefits in the form and manner prescribed by the Division..." Furthermore, 28 Texas Administrative Code §133.2, 31 Texas Register 3544, states, in pertinent part "(4) Final action on a medical bill-- (A) sending a payment that makes the total reimbursement for that bill a fair and reasonable reimbursement in accordance with §134.1 of this title (relating to Medical Reimbursement); and/or (B) denying a charge on the medical bill."

The requestor in its position statement asserts that: "The Carrier did not make a legal denial of reimbursement because Vista was not provided with a sufficient explanation or the proper denial reasons to justify the denial of reimbursement of the disputed charges."

Review of the submitted documentation finds that the explanation of benefits was issued using the division prescribed form TWCC 62 and noted claim adjustment codes of CAC-W1; 480; CAC-97; 730; W10; 420; 426; CAC-143; CAC-W4 and 891.

These payment exception codes and descriptions support an explanation for the reduction of reimbursement based on former 28 Texas Administrative Code §134.401. These reasons support a reduction of the reimbursement amount from the requested stop-loss exception payment reimbursement methodology to the standard per diem methodology amount and provided sufficient explanation to allow the provider to understand the reason(s) for the insurance carrier's action(s) for the services in dispute. The division therefore concludes that the insurance carrier has met the requirements of applicable §133.240, and §133.2.

2. 28 Texas Administrative Code §134.401(c)(6)(A)(i) states "...to be eligible for stop-loss payment the total audited charges for a hospital admission must exceed \$40,000, the minimum stop-loss threshold." Furthermore, (A) (v) of that same section states "...Audited charges are those charges which remain after a bill review by the insurance carrier has been performed..." Review of the explanation of benefits issued by the carrier finds that the carrier did not deduct any charges in accordance with §134.401(c)(6)(A)(v); therefore the audited charges equal \$55,385.36. The division concludes that the total audited charges exceed \$40,000.
3. The requestor in its original position statement asserts that "...if the total audited charges for the entire admission are above \$40,000, the Carrier shall reimburse using the Stop-Loss Methodology in accordance with the plain language of the rule contained in § 134.401(c)(6)(A)(iii). This rule does not require a hospital to prove that services provided during the admission were unusually extensive or unusually costly to trigger the application of the Stop Loss Methodology. It is presumed that the services provided were unusually extensive or unusually costly when the \$40,000 stop-loss threshold is reached." In its position statement, the requestor presupposes that it is entitled to the stop loss method of payment because the audited charges exceed \$40,000. As noted above, the Third Court of Appeals in its November 13, 2008 rendered judgment to the contrary. The Court concluded that "to be eligible for reimbursement under the Stop-Loss Exception, a hospital must demonstrate that the total audited charges exceed \$40,000 and that an admission involved...unusually extensive services." The requestor's position that it was not required to prove that the services in disputes were unusually extensive is not supported. The requestor failed to discuss the particulars of the admission in dispute that may constitute unusually extensive services, therefore, the division finds that the requestor did not meet 28 TAC §134.401(c)(6).
4. In regards to whether the services were unusually costly, the requestor states "...This rule does not require a hospital to prove that services provided during the admission were unusually extensive or unusually costly..." The third Court of Appeals' November 13, 2008 opinion concluded that in order to be eligible for reimbursement under the stop-loss exception, a hospital must demonstrate that an admission involved unusually costly services thereby affirming 28 Texas Administrative Code §134.401(c)(6) which states that "Stop-loss is an independent reimbursement methodology established to ensure fair and reasonable compensation to the hospital for unusually costly services rendered during treatment to an injured worker." The requestor's position that it was not required to prove that the services in disputes were unusually extensive is not supported. The requestor failed to discuss the particulars of the admission in dispute that may constitute unusually costly services, therefore, the division finds that the requestor failed to meet 28 TAC §134.401(c)(6).

5. For the reasons stated above the services in dispute are not eligible for the stop-loss method of reimbursement. Consequently, reimbursement shall be calculated pursuant to 28 Texas Administrative Code §134.401(c)(1) titled *Standard Per Diem Amount* and §134.401(c)(4) titled *Additional Reimbursements*. The division notes that additional reimbursements under §134.401(c)(4) apply only to bills that do not reach the stop-loss threshold described in subsection (c)(6) of this section.
- Review of the submitted documentation finds that the services provided were surgical; therefore the standard per diem amount of \$1,118.00 per day applies. Division rule at 28 Texas Administrative Code §134.401(c)(3)(ii) states, in pertinent part, that “The applicable Workers’ Compensation Standard Per Diem Amount (SPDA) is multiplied by the length of stay (LOS) for admission...” The length of stay was two days. The surgical per diem rate of \$1,118.00 multiplied by the length of stay of two days results in an allowable amount of \$2,236.00.
  - 28 Texas Administrative Code §134.401(c)(4)(C) states “Pharmaceuticals administered during the admission and greater than \$250 charged per dose shall be reimbursed at cost to the hospital plus 10%. Dose is the amount of a drug or other substance to be administered at one time.” A review of the submitted itemized statement finds that the requestor billed Thrombin USP TOP. The requestor did not submit documentation to support what the cost to the hospital was for Thrombin USP TOP. For that reason, reimbursement for these items cannot be recommended.

The division concludes that the total allowable for this admission is \$2236.00 per diem. The respondent issued payment in the amount of \$4386.50. Based upon the documentation submitted, no additional reimbursement can be recommended.

### **Conclusion**

The submitted documentation does not support the reimbursement amount sought by the requestor. The requestor in this case demonstrated that the audited charges exceed \$40,000, but failed to discuss and demonstrate that the disputed inpatient hospital admission involved unusually extensive, and unusually costly services. Consequently, 28 Texas Administrative Code §134.401(c)(1) titled *Standard Per Diem Amount*, and §134.401(c)(4) titled *Additional Reimbursements* are applied and result in no additional reimbursement.

### ***ORDER***

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the division has determined that the requestor is entitled to \$0.00 reimbursement for the disputed services.

### **Authorized Signature**

_____	_____	<u>September 2012</u>
Signature	Medical Fee Dispute Resolution Officer	Date

_____	_____	<u>September 2012</u>
Signature	Medical Fee Dispute Resolution	Date

### ***YOUR RIGHT TO APPEAL***

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision* together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a *certificate of service demonstrating that the request has been sent to the other party.***

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.**